PRINTED: 05/12/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155816		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/15/2015	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218				
(X4) ID PREFIX TAG K 000	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ГЕ	(X5) COMPLETION DATE
Bldg. 01	State Licensure State Indiana State accordance with Survey Date: 04 Facility Number: Provider Number: AIM Number: 2 At this Life Safe Arlington Place of Sound not in come Requirements for Medicare/Medicate/Medi	ty Code Survey, Health Campus was apliance with r Participation aid, 42 CFR Subpart affety From Fire and the the National Fire station (NFPA) 101, Life C), Chapter 18, New upancies and 410 IAC cility was determined to 1) construction and fully a facility has a fire alarm ke detection in the areas open to the	K 0	00			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155816		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/15/2015	
	PROVIDER OR SUPPLIER		1635 N	ADDRESS, CITY, STATE, ZIP CODE ARLINGTON AVE APOLIS, IN 46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K 027 SS=E Bldg. 01	All areas where access were spring providing facility sprinklered. NFPA 101 LIFE SAFETY CO Door openings in second	DDE STANDARD smoke barriers have at			
	at least 1¾-inch the core. Non-rated pexceed 48 inches door are permitted comply with 7.2.1. arranged so that exposite direction, and rabbets, beveorequired at the melatching is not required 18.3.7.8	fire protection rating or are nick solid bonded wood protective plates that do not from the bottom of the d. Horizontal sliding doors 14. Swinging doors are each door swings in an . Doors are self-closing els or astragals are setting edges. Positive uired. 18.3.7.5, 18.3.7.6,			
	facility failed to smoke barrier do a smoke resistan	ation and interview, the ensure 2 of 5 sets of oors would close to form t barrier. This deficient fect 65 residents, staff	K 027	Responses to the cited findings do not constitute an admission or agreement by the facility of the truth of the alleged or conclusion	04/16/2015
	Findings include			set forth in the Statement of	
	of Plant Operation facility from 1:10 04/15/15, the set	ations with the Director ons during a tour of the 0 p.m. to 3:50 p.m. on of smoke barrier doors y Room 311 and the set		Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155816	l í	UILDING	onstruction 01	(X3) DATE COMPL 04/15 /	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218					
ARLING? (X4) ID PREFIX TAG	of smoke barrier the Central Supposite direction of Packnowledged the barrier door sets opposite direction	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) doors in the corridor by bly Room D101 each posite direction and are th an astragal, rabbet or ting edge. Based on time of the observations,				re	(X5) COMPLETION DATE	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPLETED
		155816	B. W	ING		04/15/2015
		100010				0 11 10/20 10
NAME OF F	ROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE	
				1635 N		
ARLING	ON PLACE HEAL	TH CAMPUS		INDIAN	APOLIS, IN 46218	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
			+		C) With respect to what systematic	
					c, with respect to what systematic	
					measures have been put into place	
					, , , , , , , , , , , , , , , , , , ,	
					to address the stated concern:	
					Brush sweeps were installed on	
					2 of the 5 doors to form a smoke	
					resistant barrier.	
					D) With respect to how the plan of	
					corrective measures will be	
					monitored:	
					momeorea.	
					Further monitoring is not necessary	·.
					E) Date of compliance with	
					proposed actions:4/16/2015	
IV 000	NEDA 404					
K 029	NFPA 101 LIFE SAFETY CO	DE STANDARD				
SS=E	Hazardous areas					
Bldg. 01		3.4. The areas are				
		ne hour fire-rated barrier,				
		e-rated door, without				
		rdance with 8.4). Doors				
			1			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	<u>01</u>	COMPL	ETED
		155816	B. WI	NG		04/15/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	£		1635 N	ARLINGTON AVE		
ARLING	TON PLACE HEALT	TH CAMPUS			APOLIS, IN 46218		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		automatic closing in					
accordance with 7.2.1.8. 18.3.2.1		17.0	30			05/07/0015	
		ration and interview, the	K 0	29	Responses to the cited findings		05/27/2015
	-	ensure 2 of 16 doors			Nesponses to the cited infamigs		
		us areas such as fuel fired			do not constitute an admission		
	heater rooms and	d combustible storage					
	rooms measuring	g greater than 100 square			or agreement by the facility of the		
	feet each have a	3/4-hour fire protection					
	rating. This defi	icient practice could			truth of the alleged or conclusion		
	affect 60 residen	ffect 60 residents, staff and visitors.			set forth in the Statement of		
					set for the mile statement of		
Findings include:				Deficiencies. The Plan of			
	C						
	Based on observ	rations with the Director			Correction is prepared solely as		
		ons during a tour of the					
	•	0 p.m. to 3:50 p.m. on			a matter of compliance with		
		entral Supply Room D101			federal and/or state law.		
	•	160 square feet in size			rederal and/or state law.		
		ombustible supplies					
		Equipment Room E122					
	_				In response to the cited findings		
		one natural gas fired					
		I no fire resistance rating			R/T to K029, the following corrective	9	
		he entry door from the			actions were taken:		
		on interview at the time					
		ons, the Director of Plant					
	•	owledged each of the					
		hazardous areas entry			A) With respect to these findings:		
	room doors had	no fire resistance rating			<u></u>		
	label affixed to t	he door.			No residents were adversely		
					affected.		
	3.1-19(b)						
	, ,						
					B) With respect to how to facility		
					will		

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE CO ILDING	01	(X3) DATE (COMPL		
		155816	B. WI	NG	<u>•</u>	04/15/	2015	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
					identify residents with the potentia	1		
					for the identified concern and take			
					corrective action: 1(E122) of the 2			
					doors were replaced with a fire			
					resistant rated entry door. The 2nd			
					door (D101) has been ordered.			
					C) With respect to what systematic			
					measures have been put into place			
					to address the stated concern:			
					E122 has been replaced with a fire			
					resistant rated entry door. (see			
					attachment) D101 fire resistant			
					rated entry door has been ordered			
					(see attachment) with expected ship			
					date of 5/27/15.			
					D) With respect to how the plan of			
					corrective measures will be monitored:			
					Director of Plant Operations or			

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		X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI		<u>01</u>	COMPL	
		155816	B. WING			04/15/	2015
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218				
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	<u> </u>	D I			(X5)
					PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
	-				CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	
K 051 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CO A fire alarm system components, device installed according effective warning of building. Activation	n with approved ces or equipment is g to NFPA 72, to provide of fire in any part of the n of the complete fire n manual fire alarm		efix 'AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE .	COMPLETION DATE
	stations are locate Electronic or writte available. A reliab is provided. Fire a maintained in acco National Fire Alarr maintenance are k There is remote ar alarm system to ar 18.3.4, 9.6 Based on observa facility failed to electromagnetic	em operation. Pull d in the path of egress. en records of tests are elle second source of power alarm systems are ordance with NFPA 72, in Code, and records of sept readily available. Innunciation of the fire in approved central station. In action and interview, the ensure 1 of 16 exit door locks connected to the in remained unlocked.	K 051		Responses to the cited findings do not constitute an admission		05/15/2015

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	OF CORRECTION	IDENTIFICATION NUMBER:		ULTIPLE CC UILDING	ONSTRUCTION 01	COMPL	
		155816	B. W		01	04/15	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ARLINGTON AVE		
ARLING ⁻	TON PLACE HEALT	TH CAMPUS		INDIAN	IAPOLIS, IN 46218		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nrm was activated. LSC			or agreement by the facility of the		
9.6.1.3 says the provisions of 9.6 cover the basic functions of a complete fire				truth of the alleged or conclusion			
		•					
	1	ection 9.6.1.4 requires			set forth in the Statement of		
		ns comply with NFPA			Deficiencies. The Plan of		
		e Alarm Code. NFPA 72,			Deficiencies. The Plan of		
	l '	y device or system			Correction is prepared solely as		
		ate the locking or					
unlocking of exits shall be connected to					a matter of compliance with		
the fire alarm system serving the protected premises. NFPA 72, 3-9.7.2				federal and/or state law.			
states all exits connected in accordance				reactar ana, or state law.			
	with 3-9.7.1 shall unlock upon receipt of						
		gnal by means of the fire					
	*	rving the protected			In response to the cited findings		
	premises.	iving the protected			R/T to K051, the following corrective	/e	
	1 ^	re otherwise required or					
	•	authority having			actions were taken:		
	jurisdiction.	unuione, nuving					
	ľ	ractice could affect 13					
		nd visitors if needing to			A) With respect to these findings:		
	exit the facility b						
					No residents were adversely		
	Findings include	:			affected.		
	Based on observ	ration with the Director of					
	Plant Operations	s during a tour of the			B) With respect to how to facility		
	facility from 1:1	0 p.m. to 3:50 p.m. on			will		
	04/15/15, the ele	ectromagnetic lock on the			identify residents with the potenti	al	
	exit door by Roo	om 229 did not release					
	and remain unlo	cked when the fire alarm			for the identified concern and take	•	
		3:32 p.m. Based on			corrective action: 1 of 16 exit door		
		time of observation, the			Corrective action. 1 of 10 exit door		
	Director of Plant	t Operations			electromagnetic locks that remaine	ed	

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	OF CORRECTION	IDENTIFICATION NUMBER: 155816	A. BUILDING B. WING	<u>01</u>	COMPLETED 04/15/2015		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218				
(X4) ID PREFIX TAG	(EACH DEFICIEN	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	on the exit door l	e electromagnetic lock by Room 229 did not fire alarm system was		unlocked while the fire alarm was			
	activated.			activated was repaired on 4/6 /15			
	3.1-19(b)			C) With respect to what systematic			
				to address the stated concern: The			
				electromagnetic lock was repaired			
				in accordance to NFPA 72 18.3.4, 9.6	5		
				A proper written record will be			
				maintained for future inspections.			
				(See attachment)			
				D) With respect to how the plan of			
				corrective measures will be monitored:			
				Furthering monitoring is not			
				necessary.			
				E) Date of compliance with			
				proposed actions: 5/15/2015			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155816		ľ í	JILDING	ONSTRUCTION 01	(X3) DATE COMPL 04/15 /	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 052 SS=F Bldg. 01	installed, tested, a accordance with N Code and NFPA 7 approved mainten complying with ap NFPA 70 and 72. Based on record the facility failed functional testing smoke detectors NFPA 72, 7-3.2 component testing 7-3.2 which requirest of smoke describes of all inspections maintenance sha includes informa 7-5.2.2. This deaffect all residen Findings include Based on review Services "Period and Testing Republications of the property	n required for life safety is nd maintained in IFPA 70 National Electrical 2. The system has an ance and testing program plicable requirements of 9.6.1.4 review and interview, I to document annual g of all fire alarm system and duct detectors. refers to fire alarm ag frequencies in Table aires an annual functional frector initiating devices. Quires a permanent record as, testing and II be provided that tion requested in Figure ficient practice could ts, staff and visitors.	K 0	52	Responses to the cited findings do not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law. In response to the cited findings R/T to K052, the following corrective actions were taken: A) With respect to these findings:	e	05/15/2015

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155816	l í	ILDING	onstruction 01	(X3) DATE : COMPL 04/15/	ETED
NAME OF P	ROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE ARLINGTON AVE		
ARLINGT	ON PLACE HEALT	TH CAMPUS		INDIAN	APOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	detectors and du- most recent twel available for rev	alarm system smoke ct detectors within the ve month period was not iew. Review of Services "Fire Alarm			No residents were adversely affected.		
	System Record of				B) With respect to how to facility		
	_	ated 01/17/14 indicated			will		
	there are 203 sm	oke detectors, 20 manual and 7 duct detector			identify residents with the potention	al	
	-	s in the facility. Based			for the identified concern and take	•	
		he time of record review, Plant Operations stated			corrective action: Periodic Fire Alarm		
	inspection report	s for the last year was iew and acknowledged			Inspection was not yet completed		
	documentation o	f annual functional			and available for 4/15/15. It was		
	detectors and du	e alarm system smoke ct detectors within the			completed on 4/20/15 and		
	most recent twel available for rev	ve month period was not			documentation retained for		
		icw.			future reference per requirement	ts	
	3-1.19(b)				of NFPA 70 and 72. 9.6.1.4		
					C) With respect to what systemation	5	
					measures have been put into place	?	
					to address the stated concern:		
					Periodic Fire Alarm Inspection was		
					completed on 4/20/15 as it was due	e	
					4/15/15. (See attachment)		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155816	A. BUILDING B. WING	ONSTRUCTION 01	COMPLETED 04/15/2015
	ROVIDER OR SUPPLIER		1635 N	ADDRESS, CITY, STATE, ZIP CODE ARLINGTON AVE IAPOLIS, IN 46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				D) With respect to how the plan of corrective measures will be monitored: The Excutive Director and Director of Plant Operations will review Periodic Fire Alarm Inspection documentation in accordance to regulations to assure inspections are completed in within the alloted time during monthly QAA meetings and quarterly for the remaining	f
				months of 2015. E) Date of compliance with proposed actions: 5/15/2015	
K 144 SS=C Bldg. 01		spected weekly and ad for 30 minutes per			

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155816		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/15/2015		
NAME OF PROVIDER OR SUPPLIER ARLINGTON PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		ATE	(X5) COMPLETION DATE	
	3.4.4.1. 1. Based on recomplete the facility failed load test for the conducted for 1 of the three following that main exhaust gas temperating temperating that main exhaust gas temperating temperating that main exhaust gas temperating that main exhaust gas temperating that the commended by Chapter 3-4.4.1. In monthly testing emergency elect accordance with 6-4.2 of NFPA 1 sets in Level 1 and exercised at least minimum of 30 following method a. Under operating conditions or at a conditions or at a condition of the EPS named by Loading that the exhaust gas temperating shall be conditionally be conditionally as the commended by the date and time testing shall be conditionally as the condition, performed to the condition, performed that the conditions of the commended by the date and time testing shall be conditionally as the condition, performed to the condition of	ord review and interview, at to ensure a monthly emergency generator was of 12 months using one owing methods: under rature conditions, at not a the Emergency Power emeplate rating, or entains the minimum operatures as any the manufacturer. If of NFPA 99 requires of generators serving the rical system to be in NFPA 110. Chapter 10 requires generator and Level 2 service to be at once monthly, for a minutes, using one of the eds: any temperature not less than 30 percent explate rating. The maintains the minimum operatures as any the manufacturer. The of day for required decided by the owner, and operations. NFPA 99, a written record of ormance, exercising	K 1	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		
	period and repairs shall be regularly maintained and available for inspection				identify residents with the potenti	al	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155816	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/15/2015	
NAME OF PROVIDER OR SUPPLIER ARLINGTON PLACE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	NCIES ID PROVIDER'S PLAN OF CORRECTION BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		(X5) COMPLETION DATE	
	by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator Weekly Load Test" documentation with the Director of Plant Operations during record review from 10:20 a.m. to 12:30 p.m. on 04/15/15, documentation of a monthly load test for August 2014 was not available for			for the identified concern and tak	e	
				corrective action: Emergency Generators were inspected		
				weekly and exercised under load to	ior	
				30 minutes per month in accordance		
				with NFPA 99. 3.4.4.1. as of 10/1/2014		
	record review, th	n interview at the time of the Director of Plant Il maintenance staff		to current.		
	turnover caused the facility to not perform a monthly load test in August 2014 and acknowledged documentation of a monthly load test for August 2014 was not available for review. 3.1-19(b)			C) With respect to what systemati		
				measures have been put into place to address the stated concern:	e	
				NFPA 99, 3-5.4.2 requires a writter		
		ord review and interview, I to ensure a written		record of inspection, performance exercising	,	
	starting batteries	inspections of the for the generator was		period and repairs shall be regular maintained	ly	
		of 52 weeks. Chapter A 99 requires storage connection with		and available for inspection (See attachment)		
	essential electric	al systems shall be rvals of not more than 7				
days and shall be maintained in full			D) With respect to how the plan o	f		

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155816	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/15/2015			
NAME OF PROVIDER OR SUPPLIER ARLINGTON PLACE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon		corrective measures will be monitored:				
	discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte		Emergency Generator documentation				
	levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99		to be reviewed in monthly QAA and	ı			
	requires a written record of inspection, performance, exercising period, and		by the Executive Director and				
	repairs for the generator to be regularly maintained and available by the authority		Director of Operations for a period of				
	having jurisdiction. This deficient practice could affect all residents, staff		6 months.				
	and visitors.		E) Date of compliance with				
	Findings include:		proposed actions: 5/15/2015				
	Based on review of "Emergency						
	Generator Weekly Load Test" documentation with the Director of Plant						
	Operations during record review from						
	10:20 a.m. to 12:30 p.m. on 04/15/15,						
	documentation of weekly generator						
	battery inspections for the seven week						
	period of 07/28/14 through 09/08/14 was						
	not available for review. Based on						
	interview at the time of record review,						
	the Director of Plant Operations stated maintenance staff turnover caused the						
	facility to not perform weekly inspections						
	of the starting batteries for the generator						
	and acknowledged documentation of						
	weekly generator battery inspection						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>01</u>		COMPLETED		
155816		155816	B. WING			04/15/2015	
NAME OF PROVIDER OR SUPPLIER ARLINGTON PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218				
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		forementioned seven not available for review.					

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